



**THE COMMONWEALTH OF MASSACHUSETTS  
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES  
DEPARTMENT OF PUBLIC HEALTH  
DIVISION OF HEALTH PROFESSIONS LICENSURE  
239 CAUSEWAY STREET, SUITE 200  
BOSTON, MA 02114  
800-414-0168  
617-973-0800  
[www.mass.gov/dph/boards](http://www.mass.gov/dph/boards)**

**BOARD OF RESPIRATORY CARE**

**VERIFICATION OF EDUCATION**

**Directions to Applicant:** Complete the "APPLICANT SECTION" below and request that the director of your respiratory therapy program complete and sign Page 3, Verification of Education. Return the signed, completed form to the Board of Respiratory Care, 239 Causeway Street, Suite 200, Boston, MA 02114. The Board will return a final, signed copy to you.

NOTE: This form must be updated as additional competencies are achieved. Submit updated forms to the Board of Respiratory Care within 30 days of completion of additional competencies.

**Applicant Section:**

1. Applicant Name: \_\_\_\_\_  
LAST FIRST MIDDLE  
a. Previous Name [if applicable]:

\_\_\_\_\_  
LAST FIRST MIDDLE

2. Address: \_\_\_\_\_  
NO. STREET APT #

\_\_\_\_\_  
CITY/TOWN STATE ZIP CODE

3. Telephone Number(s) Day: \_\_\_\_\_ Evening: \_\_\_\_\_

4. Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**(Disclosure is mandatory)** Pursuant to G.L. c. 62C, s. 47A, the Division of Health Professions Licensure is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you are in compliance with the tax and child support laws of the Commonwealth.

5. Program/School Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Matriculation Date: \_\_\_\_\_

I authorize the above named school to release the information requested on this form to the Board of Respiratory Care. I further authorize the Board to release information contained in this section and to request pertinent additional information in connection with the processing of this application.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

DO NOT WRITE BELOW THIS LINE - FOR BOARD OF RESPIRATORY CARE USE ONLY

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Date Received:

Permit Issue Date:

Expiration Date:

THIS LIMITED PERMIT IS NOT VALID  
WITHOUT BOARD SEAL

Based on the anticipated completion date of the program you are enrolled in, your Limited Permit expires on the date listed. The expiration date of a Limited Permit may be extended by the Board, as provided in 261 CMR 2.08.

A Limited Permit shall be valid during a student's matriculation in an accredited Respiratory Care education program. A Limited Permit shall **automatically** expire upon a student withdrawal or dismissal from an accredited Respiratory Care education program. Prior to the expiration of the limited permit, the Limited Permit holder must take and pass the CRT examination and provide official documentation of same to the Board, in completion of the full license application. Failure to achieve a passing score on the NBRC CCRT examination automatically voids the Limited Permit. In this case, you must cease practice and notify the Board immediately. The Board will take appropriate action in response to unlicensed practice.

A copy of the statute & regulations pertaining to Respiratory Care is available on the Board's web site at [www.mass.gov/dph/boards](http://www.mass.gov/dph/boards) or from the State House Bookstore, Room 116, State House, Boston, MA 02133. Phone: (617) 727-2834. The statutes for Respiratory Care are Massachusetts General Laws, Chapter 13, section 11B and Chapter 112, sections 23R through 23BB. The Board regulations are 261 Code of MA Regulations, sections 2.00 through 5.00.

[Seal]

## VERIFICATION OF EDUCATION

**PROGRAM SECTION:** To be completed by Respiratory Therapy Program Director.

The individual named on this form has indicated that he/she is/was matriculated in the study of respiratory care in your program. Please complete this form and check "yes" or "no" for each of the respiratory care competencies the individual has successfully completed as of the date of this form.

NOTE: This form must be updated as additional competencies are achieved. Submit updated forms to the Board of Respiratory Care within 30 days of completion.

Applicant Name: \_\_\_\_\_

Matriculation Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Type of Program (check one): \_\_\_\_ Master's \_\_\_\_ Bachelor's \_\_\_\_ Associate's \_\_\_\_ Certificate

If currently enrolled, is in his/her \_\_\_\_ year \_\_\_\_ semester of respiratory care study.

This individual will/has complete(d) the program on: \_\_\_\_/\_\_\_\_/\_\_\_\_.

Respiratory Care Duties Successfully Completed: The applicant is eligible to perform specific procedures ONLY within the duties checked "yes". The applicant must also meet the educational program or employer's standards for these procedures in specified patient care situations.

	YES	NO
1. administration of medical gases	Y	N
2. use of gas administering devices	Y	N
3. administration of humidification and aerosols	Y	N
4. administration of aerosol medications	Y	N
5. support services for mechanically ventilated patients	Y	N
6. postural drainage	Y	N
7. bronchopulmonary hygiene	Y	N
8. breathing exercises	Y	N
9. respiratory rehabilitation	Y	N
10. cardiopulmonary resuscitation	Y	N
11. maintaining natural and artificial airways	Y	N
12. measuring ventilatory volumes, pressures, flows	Y	N
13. collecting specimens of blood and other materials	Y	N
14. pulmonary function testing	Y	N
15. hemodynamic and other related physiologic monitoring of the cardiopulmonary system	Y	N
16. teaching patients and families respiratory care procedures	Y	N
17. consultation for health educational and community agencies	Y	N
18. teaching knowledge, skills attitudes of respiratory care	Y	N

I certify that the individual named on this form has successfully completed the duties checked as "yes" and is in good academic standing in or a graduate of the program.

Program Director Name (Print): \_\_\_\_\_ School

Program Director Signature: \_\_\_\_\_ Seal

School Name: \_\_\_\_\_

Date: \_\_\_\_\_